DOC. NO. 35-05-20-99/08/20

OFFICE OF VITAL STATISTICS

CERTIFICATE OF DEATH

State of Delaware (107)

DEPARTMENT OF HEALTH AND SOCIAL SERVICES

LOCAL REG NO. STATE FILE NUMBER

TO FUNERAL DIRECTOR: After certificate has been signed by attending physician and completely filled in by funeral director, remove carbons, file parts 1 and 2 with Registrar within 72 hrs. after death and then use Burial-Transit Permit for disposition of body.

DECEDENT

1. DECEDENT'S NAME (FIRST, MIDDLE, LAST): MArissa R Fishman
2. SEX: F
3. DATE OF DEATH (MO., DAY, YR.): XX/XX/XX 8/30/02
4. SOCIAL SECURITY NO.:
5A. AGE (YRS):
5B. UNDER 1 YEAR MONTHS: 20 DAYS:
5C. UNDER 1 DAY HOURS: MINUTES:
6. DATE OF BIRTH (MO., DAY, YR.):
7. BIRTHPLACE (CITY AND STATE OR FOREIGN COUNTRY):
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ YES ☐ NO
9. ANATOMICAL GIFT ☐ CONSENT GRANTED ☐ NOT GRANTED
10A. PLACE OF DEATH (CHECK ONLY ONE, SEE INSTRUCTIONS ON OTHER SIDE) HOSPITAL ☒ INPATIENT ☐ ER/OUTPATIENT ☐ DOA OTHER ☐ NURSING HOME ☐ RESIDENCE ☐ OTHER (SPECIFY)
10B. FACILITY NAME (IF NOT INSTITUTION GIVE STREET AND NUMBER): A. I. Dupont Hospital for Children
10C. CITY, TOWN, OR LOCATION OF DEATH: Wilmington
10D. COUNTY OF DEATH: N.C.
11. MARITAL STATUS — MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (SPEC.):
12. SURVIVING SPOUSE (IF WIFE GIVE MAIDEN NAME):
13A. DECEDENT'S USUAL OCCUPATION (KIND OF WORK DURING MOST OF WORKING LIFE. DO NOT USE RETIRED):
13B. KIND OF BUSINESS/INDUSTRY:
14A. RESIDENCE — STATE: Pennsylvania
14B. COUNTY:
14C. CITY, TOWN, OR LOCATION: Chadds Ford
14D. STREET AND NUMBER: 110 Kelly Drive
14E. INSIDE CITY LIMITS? (YES OR NO):
14F. ZIP CODE:
15. WAS DECEDENT OF HISPANIC ORIGIN? (SPECIFY NO OR YES. SPECIFY CUBAN, MEXICAN, PUERTO RICAN, ETC.) ☐ NO ☐ YES (Specify)
16. RACE — AMERICAN INDIAN, BLACK, WHITE, ETC. (SPECIFY): White
17. DECEDENT'S EDUCATION (SPECIFY ONLY HIGHEST GRADE COMPLETED) ELEMENTARY/SECONDARY (0-12): COLLEGE (1-4 OR 5+):

PARENTS

18. FATHER'S NAME (FIRST, MIDDLE, LAST):
19. MOTHER'S NAME (FIRST, MIDDLE, MAIDEN SURNAME):

INFORMANT

20A. INFORMANT'S NAME (TYPE/PRINT):
20B. MAILING ADDRESS (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE, ZIP CODE):

DISPOSITION

21A. METHOD OF DISPOSITION ☐ BURIAL ☐ CREMATION ☐ REMOVAL FROM STATE ☐ DONATION ☐ OTHER (SPECIFY)
21B. PLACE OF DISPOSITION (NAME OF CEMETERY, CREMATORY, OR OTHER PLACE):
21C. LOCATION (CITY, TOWN, STATE):
22A. SIGNATURE OF FUNERAL DIRECTOR ▶
22B. LICENSE NUMBER (OF LICENSEE):
23. NAME AND ADDRESS OF FACILITY: Schoenberg
24. REGISTRAR'S SIGNATURE ▶
25. DATE FILED (MO., DAY, YR.):

PRONOUNCING OFFICIAL

COMPLETE ITEMS 26 A-C ONLY WHEN CERTIFYING PHYSICIAN IS NOT AVAILABLE AT TIME OF DEATH TO CERTIFY CAUSE OF DEATH.

26A. TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE TIME, DATE, AND PLACE STATED SIGNATURE AND TITLE ▶
26B. LICENSE NUMBER:
26C. DATE SIGNED (MO., DAY, YR.):

ITEMS 27-29 MUST BE COMPLETED BY PHYSICIAN OR HOSPICE NURSE WHO PRONOUNCES DEATH

27. TIME OF DEATH: 7:03 ☐ AM ☒ PM
28. DATE PRONOUNCED DEAD (MO., DAY, YR.): 08 - 30 - 02
29. WAS CASE REFERRED TO MEDICAL EXAMINER? (YES OR NO): Yes

SEE DEFINITION ON OTHER SIDE

CERTIFIER

30A. CERTIFIER (CHECK ONLY ONE)

☐ CERTIFYING PHYSICIAN (Physician certifying cause of death when another physician has pronounced death and completed item 26) To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☒ PRONOUNCING AND CERTIFYING PHYSICIAN (Physician both pronouncing death and certifying the cause of death) To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

30B. SIGNATURE AND TITLE OF CERTIFIER ▶ MD
30C. LICENSE NUMBER:
30D. DATE SIGNED (MO., DAY, YR.): 8/30/02
30E. NAME AND ADDRESS OF CERTIFIER WHO COMPLETED CAUSE OF DEATH (ITEM 40) (TYPE/PRINT): GLENN STRYJEWSKI, M.D. A.I. duPont Hospital 1600 Rockland Road Wilmington DE 19899

TO HOSPITAL OR PHYSICIAN — DELAWARE LAW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 72 HOURS AFTER DEATH

32A. WAS AN AUTOPSY PERFORMED? ☒ YES ☐ NO
32B. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? ☐ YES ☒ NO
33. MANNER OF DEATH ☐ NATURAL ☒ ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ PENDING INVESTIGATION ☐ UNDETERMINED
34. DATE OF INJURY (MO., DAY, YR.): 8/30/02
35. TIME OF INJURY: 7:00 ☐ AM ☐ PM
36. INJURY AT WORK? ☐ YES ☒ NO
37. DESCRIBE HOW INJURY OCCURRED: Child fell into pool
38. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. (SPECIFY)): Grandparents Home
39. LOCATION (STREET AND NUMBER OR RURAL ROUTE NUMBER, CITY OR TOWN, STATE): 3220 Coachman Rd., Surrey Park, Wilm., DE

40. PART I DO NOT ENTER THE MODE OF DYING SUCH AS CARDIAC OR RESPIRATORY ARREST, SHOCK, OR HEART FAILURE. LIST ONLY ONE CAUSE PER EACH LINE.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (FINAL DISEASE, INJURY OR CONDITION THAT IN YOUR OPINION CAUSED THE DEATH) — IMMEDIATE CAUSE (A)	Drowning	
DUE TO (B)		
SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (DISEASE OR INJURY WHICH INITIATED EVENTS RESULTING IN DEATH) LAST — DUE TO (C)		
DUE TO (D)		

PART II OTHER SIGNIFICANT CONDITIONS— CONTRIBUTING TO CAUSE OF DEATH

REV. 9/99

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